## DEPARTMENT OF HEALTH SERVICES-COUNTY OF LOS ANGELES

## NOTIFICATION OF PERSONNEL CHANGE FORM HOSPITAL PROGRAMS

**REFERENCE NO. 621.2** 

Orga	nization's Name:		-
	ctive Date:		
СНА	NGE REQUESTED: (Check all that appl	y) [ ] No Changes Necessary	
[]	Personnel Change		
Hosp	oital:		
	[ ] Base Hospital Medical Director [ ] Chief Executive Officer (CEO) [ ] Disaster Coordinator/Emergency Manageme [ ] EDAP Medical Director [ ] ED Medical Director [ ] ED Nurse Manager/Director [ ] Pediatric Liaison Nurse (PdLN) [ ] PMC/PTC Liaison Nurse [ ] PMC/PTC Medical Director [ ] Prehospital Care Coordinator (PCC) [ ] Stroke Medical Director [ ] Stroke Program Coordinator [ ] SRC Clinical Director [ ] SRC Medical Director [ ] Trauma Medical Director [ ] Trauma Program Director [ ] Trauma Surge Coordinator  Change Name From:  Change Name To/Add:	ent Officer (EMO)	
[ ]	Change Address/Contact Numbers		
	Address/Street	City/State/Zip	
	Telephone	Fax	
	Telephone: Disaster Command Post	Fax: Disaster Command Post	
	Pager Number	Cellular Telephone Number	
	E-mail address		
Name of person completing form		Title	_
Date			07-01-20